FINAL REPORT
OF THE
INTERIM STUDY COMMITTEE ON THE INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

Indiana Legislative Services Agency
200 W. Washington Street, Suite 301
Indianapolis, Indiana 46204

October, 2000

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2000

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A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Committee can be accessed from the General Assembly Homepage at **http://www.state.in.us/legislative/.**

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation directing the Committee to do the following:

(1) Study the following issues related to the Indiana comprehensive health insurance association established under IC 27-8-10:

(A) Borrowing from financial institutions to provide working capital.

(B) Premium rates, including:

(i) a maximum premium rate or range for premium rates;

(ii) consideration of health maintenance organization premiums in rate determination;

(iii) annual premium rate determination and adjustment; and

(iv) a policy providing for reduced premium rates for insureds who have Medicare coverage.

(C) The effect of Medicaid eligibility on eligibility for coverage under an association policy.

(D) A maximum total annual assessment to members, the remainder of the cost to be paid by the state.

(E) Appeals procedures allowing members to:

(i) defer assessment payments for not more than one (1) year;

(ii) make assessment payments on a monthly or quarterly basis for cause; or

(iii) reduce or suspend an assessment if payment would cause the member's net worth or reserves to decrease below statutory requirements.

(F) Membership of self-insurance plans, including:

(i) conflicts with the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.); and

(ii) mechanisms for identifying self-insurance plans.

(G) Periodic audits to ensure that all entities that assume risk for accident or sickness of individuals in Indiana are members for purposes of the annual assessment.

(H) Penalties for late payment or nonpayment of assessments.

(I) Strategies to increase the base of insured individuals and decrease costs.

(J) Establishment of an independent administrative agency.

II. INTRODUCTION AND REASONS FOR STUDY

Current Indiana law provides that the ICHIA program is to be funded through client premiums and member assessments.

Following the close of the ICHIA program's fiscal year, ICHIA is to determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss is assessed to all members (all carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana) in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year. ICHIA may also provide for interim assessments against members if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating

expenses until the association's next fiscal year is completed. Members who have paid assessments may take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these up to the amount of the assessment.

Premium rates for a given classification may not be more than150% of the average premium rate for that class charged by the five carriers with the largest premium volume in the state during the preceding calendar year.

Some interested parties argue that assessments have grown such that the members cannot fully claim the tax credits and that this funding mechanism is no longer equitable.

III. SUMMARY OF WORK PROGRAM

The Committee is a two-year committee that expires November 1, 2000. The Committee met twice in 1999. Two meetings were held in 2000: September 20 and October 26.

During the meeting on September 20, 2000, members observed a presentation by the program administrator, including a demonstration of online administrative services and the results of a survey of member carriers regarding ICHIA assessments. The Committee received testimony regarding proposals for changing the ICHIA funding mechanism, a penalty for late payment of assessments, and information regarding prescription drug benefits provided under the ICHIA program.

Committee members agreed at the September 20, 2000, meeting that the members would like to inform the legislative finance leaders about the ICHIA funding problem. The Committee requested that the lay members of the Committee, and staff, compile a final report including a summary of the issues discussed by the Committee, which could be used to present the issues to the legislative finance leaders.

IV. SUMMARY OF TESTIMONY

The Committee heard testimony from the ICHIA program administrator, members and representatives of the insurance industry, ICHIA policyholders, the Commissioner of the Indiana Department of Insurance, representatives of the Indiana State Department of Health, and individuals representing health care providers. The majority of testimony was centered on funding of the ICHIA program. A history of the ICHIA program was provided, including the original effect, and current effect, of the funding mechanism on member carriers. There was also discussion of how the Employee Retirement Income Security Act (ERISA) impacts on the funding options available to ICHIA. Concerns were raised regarding the equity of the current funding mechanism, and the solvency of member carriers considering the rising costs of the ICHIA program and the inability of the member carriers to take the full tax credit. Several proposals for changing the funding mechanism were made and discussed by the Committee. Also discussed were a possible penalty for late payment of assessments, and prescription drug benefits and cost containment measures under the ICHIA program.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The following matters discussed in this section of the final report are also discussed in more detail in Attachment A, which contains information provided during committee meetings, and related information based on cited sources:

- (1) Statutory and Operating Provisions of the Indiana Comprehensive Health Insurance Association (ICHIA)
  - (A) Establishment of ICHIA
  - (B) Eligibility
  - (C) Premiums
  - (D) Assessments
  - (E) Tax Credits
  - (F) Policy Requirements
- (2) The Health Care Financing Environment
  - (A) System Costs
    - (i) Rising Health Care Costs
    - (ii) Rising Pharmaceutical Costs
    - (iii) The Uninsured and Uninsureable
    - (iv) High Cost of ICHIA Clients
    - (v) ICHIA Participation Trends
  - (B) Recent Trends in ICHIA Operating Data
    - (i) ICHIA Financing Trends
- (3) Implications of ICHIA Financing Trends for ICHIA Payors
- (4) Other States' Mechanisms for Funding High-Risk Pools
- (5) Impact of Alternative Financing Mechanisms
  - (A) Estimated Fiscal Impact of Current Financing Arrangement for CY 2000, 2001, and 2002
  - (B) Hospital Admission Surcharge
  - (C) Assessment Cap
  - (D)Refundable Tax Credit
  - (E) Full Funding Through State Appropriations

1. Statutory and Operating Provisions of the Indiana Comprehensive Health Insurance Association (ICHIA)

The Indiana Comprehensive Health Insurance Association (ICHIA) was established under IC 27-8-10 in 1981, as a nonprofit legal entity with the purpose of assuring that health insurance is available to each eligible Indiana resident who applies to ICHIA for coverage.

ICHIA is funded through premiums and assessments to insurers, health maintenance organizations, and others that provide health insurance or health care services coverage in Indiana. The assessed entities are referred to as members.

At the close of ICHIA's fiscal year, net premiums, expenses of administration, and incurred losses for the year are determined. Net loss is assessed by ICHIA to all members in proportion to the members' respective shares of total health insurance premiums received in Indiana during the year.

Members may either take a credit against certain taxes upon revenues or income of the member or include amounts sufficient to recoup the assessment paid in the rates for premiums charged for insurance policies to which the ICHIA statute applies.

2. The Health Care Financing Environment

ICHIA operates within the same health care financing environment faced by other insurers and HMOs and is, thus, subject to similar pressures and constraints. In addition to the external factors that affect all insurers, characteristics specific to ICHIA clients and inherent to high risk pools exacerbate the funding problems.

System costs affecting ICHIA include: (1) rising health care costs resulting from expenditure increases as well as volume of health services consumed; (2) rising pharmaceutical costs resulting from a higher volume of prescription drugs purchased, which is likely to persist into the future; (3) the uninsured who are frequently insurable; (4) the uninsurable because the population served by high-risk pools tends to be those in the individual insurance market who cannot obtain individual coverage at an affordable price; (5) the high cost of ICHIA clients; and (6) recent increasing numbers of policyholders.

Over the past few years, ICHIA has experienced sizeable growth in operating costs that significantly exceeds the growth in premium receipts. The result is that ICHIA is increasingly dependent on member assessments for program funding. It is suggested that the escalation in the total cost of ICHIA in recent years is a function of inflation in health care costs, or increasing program participation by relatively high cost individuals, or both.

At the same time that ICHIA costs have undergone substantial annual growth, member premiums have been flat. Consequently, ICHIA has in recent years grown more and more dependent on member assessments for financing program costs.

Highlighting the ICHIA funding problem are: (1) a divergence in the respective rates of growth in premium receipts and assessment receipts; (2) a divergence in the average premium and the average member assessment; and (3) a change in the ratio of premium receipts to assessment receipts.

3. Implications of ICHIA Financing Trends for ICHIA Payors

The sizeable growth in the cost of operating ICHIA, the increasing dependence on insurer and HMO assessments to finance ICHIA losses, and the exclusion of a large proportion of the insured population from the assessment system has several important implications. ICHIA does not assess self-insured employer group plans due to federal Employee Retirement Income Security Act (ERISA) preemption concerns. This means that assessments are imposed on a low percentage of insurers and HMOs covering the remainder of the insured population. According to testimony, large employers are generally self-insured and this seems to be an increasing trend. As a result, the pool of insurers on which to impose the ICHIA assessments is proportionately small and is growing smaller.

Health insurers and HMOs are experiencing decreasing profit margins making it increasingly difficult for insurers and HMOs to pay ICHIA assessments. The implications of this financing

pressure may encompass not only reductions in profits, but may involve potential insolvency and premium increases that could serve to increase the size of the uninsured population.

Health insurers and HMOs paying assessments to ICHIA are reportedly not able to exhaust state tax credits for these assessments. However, one of the chief advantages of an assessment arrangement without a provision for an offsetting tax credit is that health insurers are assessed (and incur a cost) for people to whom the insurers would otherwise refuse to provide individual insurance coverage because those persons may result in large claims. With the tax credit that is provided in Indiana, potentially two-thirds of the assessments charged to insurers and HMOs end up being a liability assumed by the state.

4. Other States' Mechanisms for Funding High-Risk Pools

Other states utilize various mechanisms to fund high-risk pools. Reportedly, most states are experiencing difficulty funding these pools, and there appears to be no model funding mechanism.

5. Impact of Alternative Financing Mechanisms:

The Committee heard testimony and was provided information about several alternative financing mechanisms for ICHIA. Four of those options are considered here:

- Hospital admissions surcharge
- A cap of $20 million per year on member assessments
- A fully refundable tax credit for assessments
- Full funding of ICHIA losses via state appropriations

These options have several implications relating to the ICHIA funding situation.

The state General Fund currently pays for most ICHIA assessments in the form of reduced tax revenues. The General Fund, however, benefits from the current ICHIA financing arrangement in two ways:

(1) Some tax credits may never be taken by insurers and HMOs.
(2) The state earns interest on ICHIA assessment money between the time the assessment is imposed and the time the corresponding tax credit can be claimed in a succeeding year.

As a result of the ICHIA assessment “float”, the state’s net liability for ICHIA losses is significantly reduced in CY 2001 and CY 2002.

The impact of a hospital admission surcharge is related to who would ultimately pay the cost of the charge versus who is legally responsible for paying the charge. One of the primary weaknesses of the current ICHIA financing arrangement is apparently that the member assessments only reach a small proportion of the population of health plans. If the cost of the hospital admission surcharge is incurred by insurers and HMOs, this may impact the financial well-being of these entities. If hospitals are unable to shift the charge to insurers and insurance consumers, this may have a significant impact on the financial well-being of these entities.

The following two aspects may be considered relative to a cap on insurer assessments:

(1) The proposed cap is an average of annual assessment receipts from recent years according to the Arnett Health Plans testimony and is well below the 1999 assessment level. Such a cap would immediately create a funding gap that would have to be made up

directly by state appropriations.
(2) If an assessment cap was not adjusted for inflation and ICHIA program costs continue to increase, the member assessments would provide a decreasing percentage of funding for the program. Therefore, the funding gap would continue to grow.

One of the more important aspects of the fully refundable tax credit for ICHIA assessments would relate to its efficiency. Fully refunded assessments through a tax credit would effectively return the financing of the program to what existed when ICHIA was created: a mixture of premium revenue and tax expenditures with member assessments only facilitating the financing. A question is whether it would simply be more efficient to appropriate tax dollars to fund ICHIA losses that would otherwise be defrayed by member assessments that ultimately would be fully refunded through the tax system. The state liability under a fully refundable assessment tax credit proposal increases substantially because the state would no longer benefit from assessments that insurers and HMOs are unable to offset under the current non-refundable tax credit arrangement.

Fully covering ICHIA losses through appropriations has both advantages and disadvantages. By funding losses from general taxes, the problem of relying on a small proportion of the insured public for ICHIA funding would be eliminated. The cost of ICHIA not covered by those paying premiums would be distributed among the larger taxpaying public. Alternatively, if the state should experience an economic downturn, it could be difficult to maintain appropriation levels sufficient to cover ICHIA losses.

The state liability under the full-funding proposal increases substantially because the state would no longer benefit from assessments that insurers and HMOs are unable to offset with the tax credits, and the state would no longer obtain interest earnings from the ICHIA assessment “float”.

The Committee considered PD 3549: (1) placing a limit on an ICHIA member gross assessment of not more than 1.5% of the member's total health insurance premiums less Medicare and Medicaid revenues; (2) providing that a member may submit unused tax credits to the ICHIA board to reduce the member's assessment; (3) requiring the ICHIA board to request reimbursement for an amount equal to the reduction in assessments; and (4) appropriating funds from the state general fund for ICHIA costs that exceed assessments and premiums.

The Committee made no recommendations.

W I T N E S S L I S T

David Bodle, Henderson Daily Withrow and DeVoe representing M-Plan
Jim Brunnemer, Arnett HMO and Indiana Association of Health Plans
Jim Bucher, Outsourced Administrative Systems, Inc. (OASYS)
James Carr, ICHIA policyholder
John Gerni, Association of Indiana Life Insurance Companies
Bruce Greenberg, Partner's Health Plan and Indiana Association of Health Plans
Tim Kennedy, Indiana Hospital and Health Association
Sally McCarty, Indiana Department of Insurance
Scott Mingee, OASYS
Donna Olsen, parent of ICHIA policyholders
Pat Reed, consultant, Indiana State Department of Insurance
Dan Seitz, Bose McKinney and Evans
Alex Slabosky, M-Plan and Indiana Association of Health Plans
Matt Weisgerber, OASYS

*The minutes for the September 20, 2000, meeting of the Committee were amended on October 4, 2000. The portion amended is on page 3, paragraph 3, regarding registration of and reporting by third party administrators.

I. Statutory Provisions of the Indiana Comprehensive Health Insurance Association (ICHIA)

This section summarizes the statutory requirements for ICHIA as specified in IC 27-8-10.

Establishment of ICHIA

The Indiana Comprehensive Health Insurance Association was established as a nonprofit legal entity with the purpose of assuring that health insurance is available to each eligible Indiana resident who applies to ICHIA for coverage.

All insurers, health maintenance organizations (HMOs), and others providing health insurance or health care services coverage in Indiana must be members of ICHIA. The ICHIA board of directors exercises the powers granted to ICHIA under Indiana law. The ICHIA plan of operation and any amendments to the plan must be approved by the Commissioner of the Indiana Department of Insurance. The plan of operation must provide for fair, reasonable, and equitable administration of ICHIA, and provide for the sharing of ICHIA losses on an equitable, proportionate basis among the members. The statute allows ICHIA to delegate certain functions. [Note: ICHIA has delegated administrative functions to Outsourced Administrative Systems, Inc. (OASYS).]

ICHIA is required to have an audit of ICHIA operations prepared annually by an independent certified public accountant. Annual financial reports are provided to the Indiana Department of Insurance. ICHIA and premiums collected by ICHIA are exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income tax, or any combination of these or similar state taxes upon revenues or income.

Eligibility

A resident of Indiana is eligible for coverage under an ICHIA policy if:

(1) the individual has been rejected by one carrier for coverage under any insurance plan that meets or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the ICHIA plan rate; or

(3) the individual is a federally eligible individual; and

the individual is not eligible for Medicaid, is not eligible for Medicare and is 65 years of age or older, and is not covered under or eligible for coverage under a group insurance plan.

Premiums

Premium rates for coverage issued by ICHIA may not be unreasonable in relation to benefits provided, risk experience, and reasonable expense of providing coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the additional morbidity and administrative expenses for risks insured by ICHIA. Rates for a given classification may not exceed 150% of the average premium rate for that classification charged by the 5 carriers with the largest premium volume in Indiana during the preceding calendar year. Actuarial adjustments are made to determine the average premium rate charged by the 5 carriers to determine the rate that would be charged by the carriers for benefits that are identical to ICHIA benefits.

Assessments

At the close of ICHIA's fiscal year, ICHIA determines the net premiums, expenses of administration, and incurred losses for the year. Net loss is assessed by ICHIA to all members in proportion to the members' respective shares of total health insurance premiums, excluding Indiana Medicaid contracts, received in Indiana during the calendar year that ends during ICHIA's fiscal year. The statute provides that another equitable basis may be provided in the plan of operation. [Note: The current plan of operation includes the statutory method of assessing net loss.] The proportionate share of losses for health maintenance organizations, limited service health maintenance organizations, and self insurers that are members of ICHIA is determined through application of an equitable formula based on claims paid, excluding Indiana Medicaid contract claims, or the value of services provided.

ICHIA may abate or defer any part of the assessment if the Board believes that payment of the assessment would endanger the ability of the member to fulfill the member's contractual obligations. [Note: ICHIA makes two assessments per year (May and November).]

Should ICHIA experience net gains, the gains are required to be either held at interest to offset future losses or allocated to reduce future premiums.

Tax Credits

Members who have paid an assessment during the calendar year may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these or similar taxes upon revenues or income of member insurers up to the amount of the taxes due for the calendar year in which the assessment was paid and for succeeding years until the aggregate of the assessments have been offset by either credits against those taxes, or refunds from ICHIA; or

(2) include in the rates for premiums charged for insurance policies to which the ICHIA statute applies, amounts sufficient to recoup a sum equal to the amounts paid to ICHIA by the member less any amounts returned to the member insurer by the association and the rates may not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

ICHIA Policy Requirements

Under the statute, ICHIA policies may pay usual and customary charges or use managed care reimbursement systems, including fixed fee schedules and capitated reimbursement. Payment is made for covered, medically necessary eligible health care services for the diagnosis or treatment of illness or injury that exceeds the policy's deductible and coinsurance amounts. The policy must include coverage for:

(1) hospital services up to 180 days/year;
(2) professional physician and allied health professional services for diagnosis or treatment, not including mental or dental diagnosis and treatment;
(3) the first 20 professional visits for diagnosis or treatment of mental conditions rendered by a physician and allied health professionals;
(4) drugs and contraceptive devices requiring a prescription;
(5) skilled nursing facility services up to 180 days /year;
(6) home health services up to 270 days/year;
(7) radium or other radioactive materials;
(8) oxygen;
(9) anesthesia;
(10) prostheses, except dental prostheses;
(11) rental of durable medical equipment;
(12) diagnostic x-rays and laboratory;
(13) certain oral surgery;
(14) physical therapy and speech therapy;
(15) ambulance services to the nearest treatment facility; and
(16) other medical supplies required under a physician's order.

Certain expenses may not be covered under ICHIA such as custodial care, services for which a charge would not be made in the absence of insurance, worker's compensation claims, and charges outside the scope of the provider's practice.

The ICHIA policy that is required under the statute must impose a $500 deductible per person per policy year. The deductible must be applied to the first $500 of eligible expenses incurred by the covered person. A mandatory coinsurance requirement of 20% of eligible expenses in excess of the mandatory deductible is imposed. The maximum aggregate out of pocket payments for eligible expenses may not exceed $1,500 per individual, or $2,500 per family, per policy year.

Under the statute, ICHIA may issue additional types of policies with different types of benefits that the Board determines will benefit Indiana citizens.

ICHIA offers three plans: Plan 1 (as required by statute); Plan 3A; and Plan 3B (see table below). Plans 3A and 3B, with higher out-of-pocket costs, are plans that have been developed and offered because the ICHIA Board determined that these policies would benefit Indiana citizens. All three plans include a preferred provider organization (PPO) benefit: 80% paid by the plan after 20% coinsurance is paid by the covered individual. A covered individual who receives services

outside the PPO has coverage with 60% paid by the plan after 40% coinsurance is paid by the covered individual.

Plan 1	**Deductible**	$500
	Coinsurance	
	In-Network:	80% ICHIA/20% Member
	Out-of-Network:	60% ICHIA/40% Member
	Out-of-Pocket Maximum	$1,000 + Deductible
Plan 3A	**Deductible**	$1,000
	Coinsurance	
	In-Network:	80% ICHIA/20% Member
	Out-of-Network:	60% ICHIA/40% Member
	Out-of-Pocket Maximum	$2,000 + Deductible
Plan 3B	**Deductible**	$1,500
	Coinsurance	
	In-Network:	80% ICHIA/20% Member
	Out-of-Network:	60% ICHIA/40% Member
	Out-of-Pocket Maximum	$2,500 + Deductible

An ICHIA policy may impose a 3 month preexisting condition exclusion for conditions for which medical advice or treatment was recommended or received within 3 months before the effective date of coverage. An ICHIA policy may not impose a preexisting condition exclusion if the individual applies for an ICHIA policy within 6 months after termination of coverage under a health insurance plan and the person is eligible for an ICHIA policy.

Prescription drug benefits are provided through ProVantage Prescription Benefit Management, Inc. Under Plan 1, a discount is provided at the point of purchase. The member pays 100% of the cost at the point of purchase, and submits expenses to ICHIA for reimbursement. A 20% coinsurance amount applies to member reimbursement. Under Plan 3A, a $100 deductible applies independently of the deductible for medical services under the plan. Under Plan 3B, a $150 deductible applies independently of the deductible for medical services under the plan. Under Plans 3A and 3B, a 30-day supply of medicine has a copayment of $15 for brand name drugs and $8 for generic drugs.

ICHIA is authorized under the statute to issue Medicare supplement policies, but does not do so at this time.

II. The Health Care Financing Environment

ICHIA operates within the same health care financing environment faced by other insurers and HMOs and is, thus, subject to similar pressures and constraints. In addition to the external factors that affect all insurers, characteristics specific to ICHIA clients and inherent to high risk pools exacerbate the funding problems.

System Costs

Characteristics that impact on insurers, generally, and ICHIA, specifically, include rising price levels and volume of health care services consumed by individuals, the growth in expenditures for pharmaceuticals, and the general increase in the number of uninsured.

Rising Health Care Costs

Health care costs have risen faster than the Consumer Price Index[1] (CPI) for all items since 1982, the year ICHIA was implemented. From August 1982 through August 2000, the average annual increase for the CPI for all items was 3.22% per year. For the same time period, the CPI for medical care rose by 5.89% annually, while the CPI for medical care services increased by 6.00% annually.

Increases in price levels are responsible for only part of the expenditure increases, however. Volume of health services consumed by individuals has also increased. The Employee Benefit Research Institute (EBRI) describes the National Health Expenditures[2] (NHE), a measure reflecting both price and quantity, as having increased significantly since 1980, as well. From 1980 through 1998, NHE has grown by 8.9% annually: 6.4% per year between 1980 and 1990; 11.0% per year between 1990 and 1998. The Health Care Financing Administration projects average annual increases in National Health Expenditures of 6.6% per year through 2008.[3]

Rising Pharmaceutical Costs

Expenditures for prescription drugs have tended to grow at double-digit rates averaging 11.9% per year in the 1990's: from a low of 8.7% in 1993 to a high of 15.4% in 1998. As a result, prescription drug expenditures, as a percentage of National Health Expenditures, have increased from 5.4% in 1990 to 7.9% in 1998.

Price level increases were primarily responsible for the prescription drug expenditure growth in

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[1] U.S. Bureau of Labor Statistics

[2] "EBRI Notes", Employee Benefit Research Institute, July 2000.

[3] Ibid.

the early 1990's. However, since about 1993, the major factor affecting expenditure growth has been the higher volume of prescription drugs purchased. Consequently, this expenditure growth is likely to persist into the foreseeable future[4].

The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services projects the average annual percentage change in per capita expenditure for prescribed medicines to be 8.03% (between 1996 and 2005) for the U.S. population under the age of 65. This contrasts with a projected average annual increase in total personal health care expenditures of 7.11% per year.

The Uninsured and the Uninsurable

The number of Hoosiers without insurance coverage can affect the ICHIA program. According to EBRI[5], about 18.4% of Americans are uninsured. The number of uninsured Hoosiers is estimated to be 16.1%, up from 14.3% in 1993. Communicating for Agriculture (CA) states that the vast majority of the uninsured are, in fact, insurable: the uninsured tend to be young, healthy, full-time workers. CA adds that 70% of all uninsured periods last one year or less, half end within four months, and only 15% last longer than 24 months. However, CA states that perhaps only one percent of the population is both "uninsured" and "uninsurable."[6]

The population served by state high-risk pools tends not to be employees of large companies or individuals with access to large group plans. Rather, according to CA, "High-risk pools largely serve those who are in the individual insurance market -- the small-businessman, employees of small businesses that don't offer insurance, the self-employed, and other workers who are not a part of a large employer plan..."[7]

High Cost of ICHIA Clients

The ICHIA program has experienced significant growth in cost since 1990 - from $14.85 M in 1990 to $43.54 M in 1999 (a 193% overall increase or 12.7% per year). Total program costs are a function of the average member cost and the total number of members. The average member cost (where cost = premium receipts + assessment receipts) has increased substantially from $4,821 in 1990 to $10,254 in 1999 (a 113% overall increase or 8.75% per year). And even if the average member costs were to remain at the 1999 level, the total program cost will increase substantially during the current year given the spike in program participation that has apparently occurred in

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[4] Ibid.

[5] "EBRI Notes", Employee Benefit Research Institute, January 2000.

[6] Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 13th Edition, Communicating for Agriculture (CA), 1999, p.7

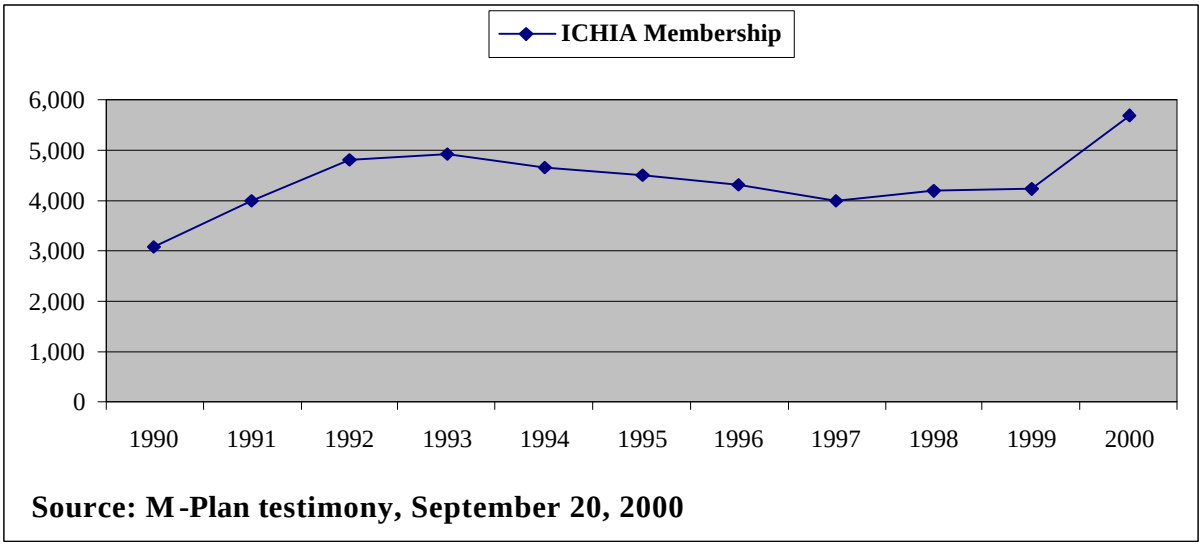
[7] Ibid., p. 6.

2000 (as described below). The average estimated per member cost in 1999 for ICHIA of $10,254 compares to an estimated $2,229 in per capita health expenditure for the population under age 65 for 1999[8] .

ICHIA Participation Trends

Membership in ICHIA has risen from 3,080 members in 1990 to nearly 5,700 members at the end of August 2000.[9] However, membership has not trended upward steadily during this time period. Rather, ICHIA membership rose sharply from 3,080 in 1990 to 4,924 in 1993 (a 59.8% increase) but then declined by 13.8% from 1994 to 1997.[10] Only during the last three years has membership again been on the rise, with a substantial membership spike beginning in 1999. [See Figure 1.] Specifically, membership has grown from 4,246 in 1999 to 5,694 in 2000, a 34.1% increase in roughly a year.[11]

Figure 2



Source: M-Plan testimony, September 20, 2000

Two factors that may have contributed significantly to ICHIA membership growth since 1997 are passage of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and a change in state policy in subsidizing the health care of individuals with AIDS/HIV.

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[8] Agency for Healthcare Quality and Research, U.S. Department of Health and Human Services, August 1998.

[9]M-Plan testimony, September 20, 2000.

[10]M-Plan testimony, September 20, 2000.

[11]M-Plan testimony, September 20, 2000.

HIPAA allowed states to designate their high-risk pools as the "alternative mechanism" for the purpose of providing availability guarantees for people leaving qualified group coverage for the individual insurance market. The use of states' high-risk pools for this purpose is in lieu of requiring insurers within the state to meet the guaranteed issue requirements of the individual market reforms within HIPAA. Consequently, there is likely to be added participation in ICHIA due to this designation.

A second factor influencing recent membership growth is a result of the change in approach used by the Indiana State Department of Health (SDH) in funding health care for certain AIDS/HIV, hemophilia, and kidney disease patients. Previous to this change, the SDH paid the entire cost of care for certain individuals suffering from AIDS/HIV, hemophilia, and kidney disease. The SDH is now funding ICHIA premiums to allow enrollment of these individuals in the ICHIA program. The number of individuals includes 900 AIDS/HIV patients, 38 hemophilia patients, and eight kidney disease patients for a total of 946 individuals. The total premium cost of $1,915,318 includes funds from the federal Ryan White CARE Act, Title II Grant ($1,808,698); the State Chronic Disease Fund ($91,507); and the Maternal Child Health Title V Federal Block Grant ($15,113). This, for the most part, represents a one-time increase that is largely completed but the number served will likely continue in lieu of any change in State Department of Health policy.

Recent Trends in ICHIA Operating Data.

ICHIA program data indicates that over the last three to four years, ICHIA has experienced sizeable growth in operating costs that exceeds the growth in premium receipts by a significant margin. [See Table 1.] As a result, ICHIA is becoming increasingly dependent on member assessments for program funding. Additionally, it appears that the ICHIA funding problem is not necessarily related to significant increases in program participation. While program participation is up substantially during the current year, membership actually declined by 1.5% during the period 1996-99 when program costs escalated at a rate well above that encountered during the preceding 4-year period. Consequently, this suggests that the escalation in the total cost of ICHIA in recent years is more a function of inflation in health care costs or increasing program participation by relatively high cost individuals, or both.

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Table 1. ICHIA Program Data: 1990 - 2000.

	ICHIA Premiums ($ M)	ICHIA Assessments ($ M)	ICHIA Cost ($ M)	ICHIA Membership	Annual % Change in ICHIA Premiums	Annual % Change in ICHIA Assessments	Annual % Change in ICHIA Cost	Annual % Change in ICHIA Membership	Average ICHIA Member Premium	Average ICHIA Member Assessment	Average ICHIA Member Cost	Annual % Change in Average ICHIA Member Cost	Ratio of ICHIA Premiums to ICHIA Assessments
90	$7.54	$7.31	$14.85	3,080					$2,448	$2,373	$4,821		103.15%
91	$8.83	$13.25	$22.07	3,684	16.98%	81.26%	48.65%	26.35%	$2,214	$3,326	$5,540	14.96%	66.57%
92	$11.62	$15.91	$27.53	4,791	31.75%	20.08%	24.74%	30.26%	$2,425	$3,321	$5,746	3.73%	73.04%
93	$12.85	$14.53	$26.14	4,664	10.56%	-8.66%	-5.05%	-2.68%	$2,756	$3,098	$5,618	-2.26%	103.46%
94	$15.31	$10.71	$26.52	4,638	6.68%	-25.21%	-8.99%	-5.81%	$3,409	$2,309	$5,718	-3.38%	142.62%
95	$15.78	$17.47	$33.25	4,483	0.19%	63.12%	25.38%	-3.34%	$3,520	$3,897	$7,417	29.71%	90.33%
96	$15.36	$17.00	$32.36	4,313	-2.66%	-2.69%	-2.68%	-3.79%	$3,561	$3,942	$7,503	1.16%	90.35%
97	$14.91	$17.51	$32.42	3,997	-2.93%	3.00%	0.19%	-7.33%	$3,730	$4,381	$8,111	8.11%	85.15%
98	$15.38	$23.11	$38.69	4,708	3.16%	31.98%	19.34%	17.80%	$3,267	$5,469	$9,164	12.96%	67.46%
99	$15.99	$27.55	$43.54	4,246	3.63%	19.21%	12.54%	-9.80%	$3,766	$6,488	$10,254	11.53%	58.04%
00				5,694				34.10%					
Change 90-1999	112.07%	276.88%	193.20%	37.86%					53.83%	173.39%	112.68%		
Change 96-1999	4.10%	62.06%	34.55%	-1.55%					5.74%	64.62%	36.67%		
Change 92-1995	35.80%	9.81%	20.78%	-6.43%					45.13%	17.35%	29.08%		

Source: M-Plan testimony, September 20, 2000.

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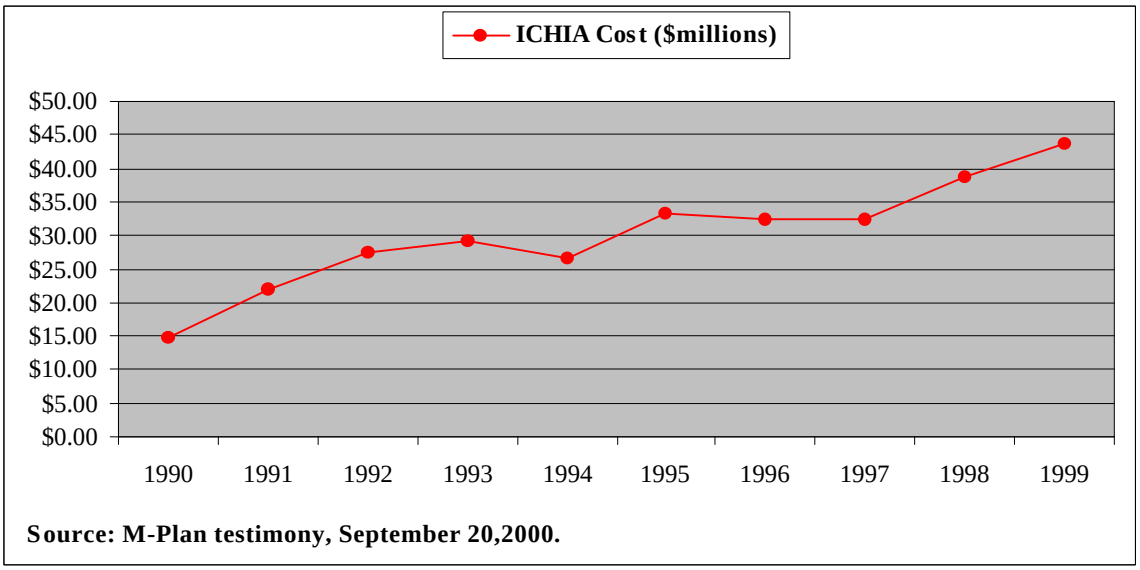
ICHIA Financing Trends

Several trends in the ICHIA data serve to highlight various aspects of the ICHIA funding problem, in particular, the escalation in ICHIA program costs and the increasing dependence on member assessments to finance these costs. The ICHIA Program has experienced significant growth in operating cost (where cost = premium receipts + assessment receipts) since 1990 - from $14.85 million in 1990 to $43.54 million in 1999. In relative terms, this amounts to a cost increase of 193.2% for the 10-year period. [See Figure 2.]

Figure 3

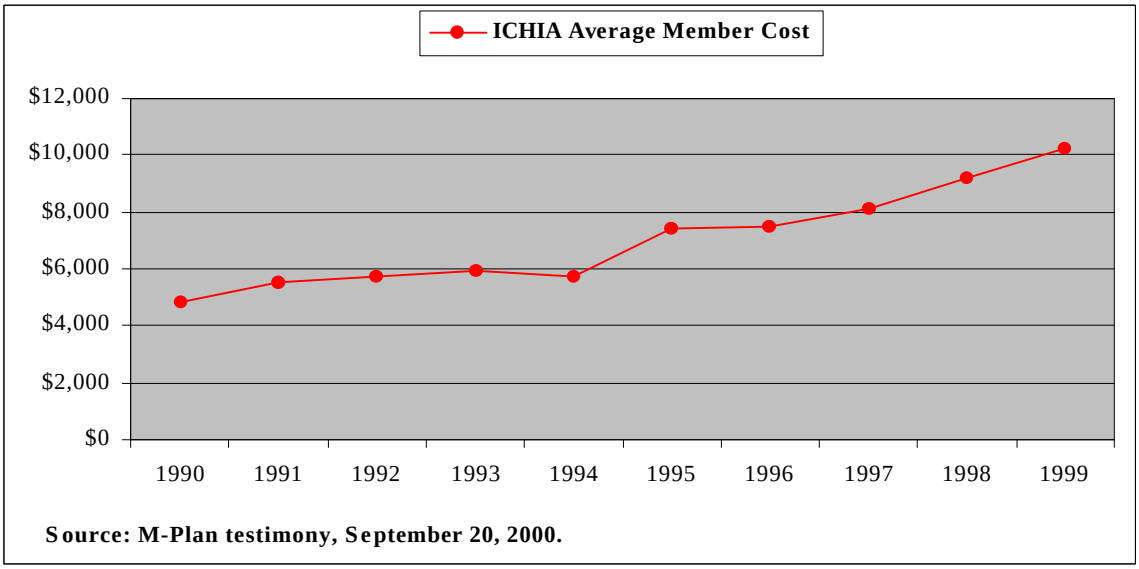


Source: M-Plan testimony, September 20,2000.

What's more, the average member cost (where cost = premium receipts + assessment receipts) has increased substantially from $4,821 in 1990 to $10,254 in 1999. This represents a a 112.68% increase in the average member cost. (See Figure 3) Even if we assume that the average member cost will remain fixed at the 1999 level, the operating cost of ICHIA will likely increase substantially during the current year given the spike in program participation outlined above.

While both the ICHIA program cost and the average member cost have consistently trended upward since 1990, the program has experienced some escalation in cost during the last four years relative to the preceding four-year period. Overall program cost (where cost = premium receipts + assessment receipts) has increased from $32.36 million in 1996 to $43.54 million in 1999 - a 34.55% increase. This is roughly 15% higher as compared to the period 1992-95 in which program costs rose by 20.78%. The average member cost has escalated in similar fashion - from $7,503 in 1996 to $10,254 in 1999 or a 36.67% increase. This is compared to a 29.08% increase in the average member cost from 1992 to 1995.

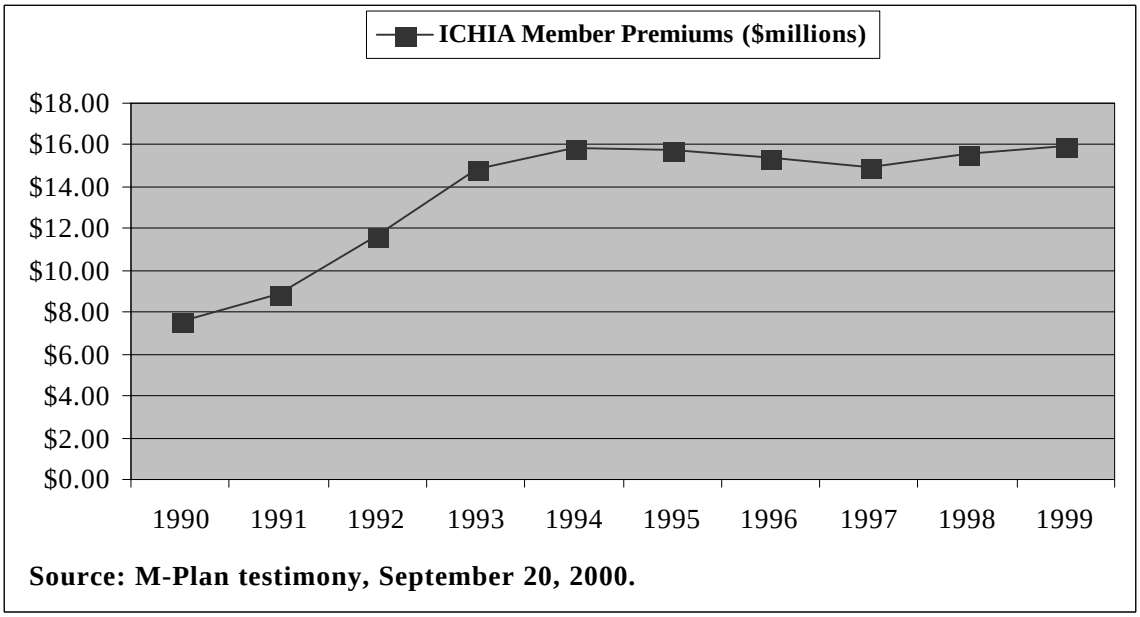
Figure 4



Source: M-Plan testimony, September 20, 2000.

At the same time that ICHIA costs have undergone substantial annual growth, member premiums have been flat (See Figure 4). Consequently, ICHIA has in recent years grown more and more dependent on the member assessments for financing the program cost.

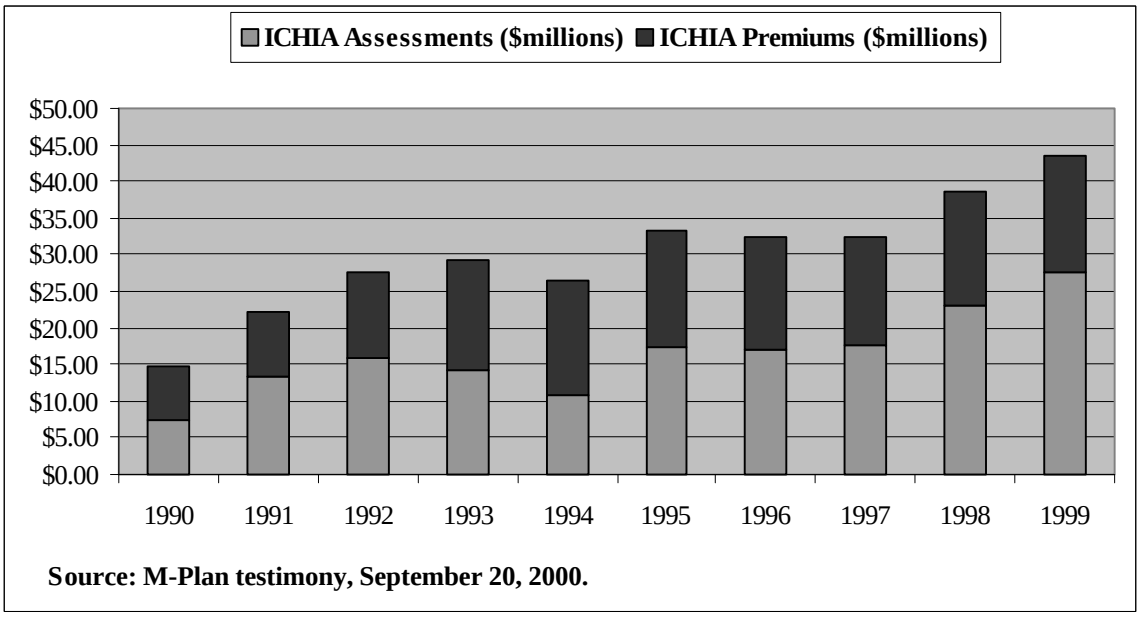
Figure 5



Source: M-Plan testimony, September 20, 2000.

The divergence in the respective rates of growth in premium receipts and assessment receipts; the divergence in the average member premium and the average member assessment; and the change in the ratio of premium receipts to assessment receipts highlights this aspect of the ICHIA funding problem. In recent years, assessment receipts have grown substantially relative to premium receipts. While premium receipts increased by only 7.24% from 1996 to 1999, assessment receipts increased by 57.34% during the same period. In comparison, premium receipts increased by 35.8% and assessment receipts by only 9.81% during the period 1992 to 1995 (See Figure 5).

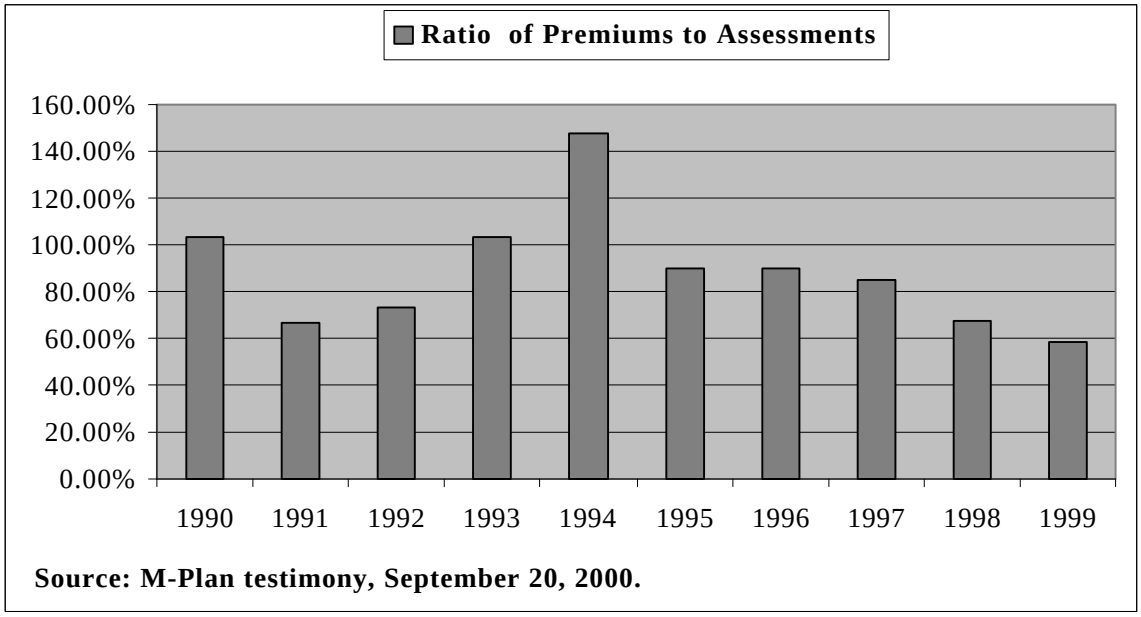
Figure 6



Source: M-Plan testimony, September 20, 2000.

Likewise, the average member premium has increased by only 5.74% during the last four years while the average member assessment has increased by 64.62%. Finally, the ratio of premiums to assessments in 1999 was 58.04%, well below the high of 147.62% in 1994 and 103.15% in 1990. This ratio has fallen sharply since 1994 (see Figure 6).

Figure 7



Source: M-Plan testimony, September 20, 2000.

III. Implications of ICHIA Financing Trends for ICHIA Payors

According to testimony[12], as originally intended, insurers and HMOs were to facilitate ICHIA by advancing funds to the state for claim payment shortfalls with the promise of the state that those funds would be recouped through the use of tax credits. This was done for two reasons: (1) because of the difficulty in projecting the excess of claims over premiums, the normal budgeting process of the state would be difficult to adapt to the needs of ICHIA; and (2) it was a way politically to finesse the issue of a new state spending program.

The sizeable growth in the cost of operating ICHIA coupled with: (1) the increasing dependence on insurer and HMO assessments to finance ICHIA losses; and (2) the exclusion of a large proportion of the insured population from the assessment system; has several important implications.[13] To begin with, the federal case law concerning the Employee Retirement Income

[12] Dan Seitz, September 20, 2000.

[13]For information relating to the exclusion of portions of the insured population from the assessment system, see Arnett Health Plans testimony (September 20, 2000) and Communicating for Agriculture. (1999) Comprehensive Health Insurance for High-Risk

Security Act (ERISA) suggests that ERISA prohibits ICHIA from imposing assessments on self-insured employer group plans. As a result, the assessments are imposed on insurers and HMOs reportedly covering only about 30% of the insured population.[14] Also on this point, reportedly about 50% of people who have employer-sponsored insurance are covered by self-insured plans that are excluded from assessment systems like that operated for ICHIA.[15] According to testimony[16], large employers are generally self-insured and this seems to be an increasing trend. As a result, the pool of insurers on which to impose the ICHIA assessments is proportionately small and is growing smaller.

Second, health insurers and HMOs are experiencing decreasing profit margins. According to testimony[17], because of these declining profit margins, it is becoming increasingly difficult for insurers and HMOs to pay the ICHIA assessments. The implications of this financing pressure may encompass not only reductions in profits, but may involve potential insolvency and premium increases that could serve to increase the size of the uninsured population.

Finally, health insurers and HMOs paying assessments to ICHIA are reportedly not able to exhaust the state tax credits for these assessments, possibly due to the growth in ICHIA assessments or the reduced profit margins of members, or both. According to an OASYS survey, insurers and HMOs that paid assessments during 1996, 1997, and 1998 were, on average, able to write-off only 67.5% of those assessments under the tax credit system.[18] Again, the implications of member companies not being able to fully exhaust the tax credit for one reason or another may contribute to premium increases and possible insolvency that may serve to increase the size of the uninsured population. It is important to note, however, that one of the chief advantages of an assessment arrangement without a provision for an offsetting tax credit is that health insurers are assessed (and incur a cost) for people they would otherwise refuse to provide individual

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Individuals: A State-By-State Analysis. Fergus Falls, MN: Communicating for Agriculture, Inc. p. 18.

[14]Arnett Health Plans testimony, September 20, 2000.

[15]Communicating for Agriculture. (1999) Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis. Fergus Falls, MN: Communicating for Agriculture, Inc. p. 18.

[16] Mr. Alex Slabosky (M-Plan), September 20, 2000.

[17] Mr. Alex Slabosky (M-Plan) and Mr. Bruce Greenberg (Partners Health Plan), September 20, 2000.

[18]OASYS Assessment Survey. The survey was returned by 276 member companies, 170 of which paid an assessment in 1998. Survey respondents represented over three-fourths of the ICHIA assessments paid during 1996, 1997, and 1998.

insurance coverage to because those persons may result in large claims.[19] With the tax credit that is provided in Indiana, potentially two-thirds of the assessments charged to insurers and HMOs end up being a liability assumed by the state.

IV. Other States' Mechanisms for Funding High-Risk Pools

The Committee heard testimony and was provided information about several alternative financing mechanisms for ICHIA, including options being considered by the Indiana Association of Health Plans (IAHP).[20] The various additional or alternative sources of funding cited by IAHP include the following:

- General fund appropriations.
- Hospital assessments.
- Assessment on insurance policy holders.
- Taxes on cigarettes and alcohol.
- Funds from unclaimed property.
- A fee imposed on each state income tax filer.
- State lottery funds.

Additional proposals for funding noted by CA or suggested in testimony include:

- Making the ICHIA tax credits refundable.
- Raising premium rates.
- Capping member assessments.
- Assess reinsurance premiums.
- Assess third-party administrators (TPAs).

Looking at other states, most high-risk pool arrangements continue to use a combination of participant premiums and assessments on health insurers and HMOs to defray program losses. [See Table 2.]. Only two states (Florida and Texas) that reportedly use assessments to cover program losses actually cap the assessment levels. In addition, 14 states provide for a tax credit (typically against either or both the insurance premium tax and the income tax) to offset the assessments.

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[19]Communicating for Agriculture. (1999) Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis. Fergus Falls, MN: Communicating for Agriculture, Inc. pp. 17-18.

[20]Arnett Health Plans testimony

Table 2. Methods of Funding State Health Insurance Programs for High-Risk Individuals: by State.

State	Premium	Assessment	Assessment Cap	Tax Credit Offset of Assessments	Appropriation	Other
Alabama	X	X		X		
Alaska	X	X				
Arkansas	X	X				
California[1]	X					X
Colorado[2]	X					X
Connecticut	X	X				
Florida	X	X	X			
Illinois	X				X	
Indiana	X	X		X		
Iowa	X	X		X		
Kansas	X	X		X		
Louisiana[3]	X				X	X
Minnesota	X	X			X	
Mississippi	X	X				
Missouri	X	X		X		
Montana	X	X		X		
Nebraska	X	X		X		
New Mexico	X	X		X		
North Dakota	X	X		X		
Oklahoma	X	X		X		
Oregon	X	X				
South Carolina	X	X		X		
Texas	X	X	X	X		
Utah	X				X	
Washington	X	X		X		
Wisconsin	X	X				
Wyoming	X	X		X		

1 Program losses are defrayed with cigarette and tobacco tax revenues.
2 Program losses are defrayed with receipts from unclaimed property.
3 Program losses are also defrayed with charges on inpatient hospital admissions and outpatient procedures.

Source: Communicating for Agriculture, Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis, 1999.

Presently, Illinois, Louisiana, Minnesota, and Utah make general fund appropriations to defray losses of the high-risk pool. All of these states require participants to pay a premium for insurance coverage. However, Minnesota and Louisiana make general fund appropriations in addition to imposing industry assessments, while Illinois and Utah make appropriations in lieu of imposing industry assessments. In particular, Louisiana imposes a charge on inpatient and

outpatient hospital admissions.

Finally, California and Colorado utilize dedicated revenue sources to defray losses of the high-risk pool. Again, both states require participants to pay a premium for insurance coverage. California utilizes cigarette and tobacco tax revenues, and Colorado taps proceeds from unclaimed property to finance program losses.

V. Impact of Alternative Financing Mechanisms:

Of the various options listed, above, the four specific options focused on in testimony by IAHP and in discussion by the Committee were the following: (1) a hospital admissions surcharge; (2) a cap of $20 million per year on the ICHIA member assessments; (3) a fully refundable tax credit for assessments; and (4) full funding of ICHIA losses via state appropriations. These options have several implications relating to the ICHIA funding situation.

Estimated Fiscal Impact of Current Financing Arrangement for CY 2000, 2001, & 2002

The net state liability for ICHIA is estimated to be $27.44 million in CY 2001 and $29.2 million in CY 2002 under the current financing arrangement, as described below.

Under the current financing arrangement member premiums finance a portion of ICHIA operating cost. Assessments are imposed on health insurers and HMOs in May and November each calendar year to finance program losses (administrative cost and incurred losses from claims in excess of member premiums). Insurers and HMOs who have paid assessments to ICHIA are currently permitted to take a dollar-for-dollar credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, up to the amount of taxes due each calendar year in which the assessments were paid. Remaining assessments can be credited in succeeding years until the total of the assessments have been offset. Thus, the state General Fund is already paying for most ICHIA assessments in the form of reduced tax revenues. We estimate program losses (costs exceeding aggregate premiums paid) to increase from about $41.8 million in CY 2001 to over $44.5 million in CY 2002, and tax credits to increase from about $28.24 million in CY 2001 to just over $30.0 million in CY 2002 (see Table 3).[21]

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[21] The following assumptions are made in estimating program losses and tax credits: (1) ICHIA membership will remain fixed at the August 31, 2000, level of 5,694 reported in the M-Plan testimony (September 20, 2000); (2) the average member cost computed for CY 1999 based on M-Plan's data will grow at an annual rate of 6% - equal to the annual increase in the CPI for medical care services since 1982; (3) the average member premium for CY 1999 based on M-Plan's data will grow at an annual rate of 5.28% - equal to the average annual growth rate since 1990; and (4) companies will be able to take tax credits equal to 67.5% of the assessments paid. each year under the current non-refundable tax credit arrangement - equal to the average offset from 1996-98 reported in the OASYS survey, September 20, 2000.

Table 3. Fiscal Impact of Current ICHIA Financing Arrangement				
Calendar Year	Program Losses	Tax Credits	Interest Earned from "Float"	Net State Liability
2001	$41,834,990	$28,238,618	$797,741	$27,440,877
2002	$44,516,218	$30,048,447	$848,869	$29,199,578

The General Fund, however, benefits from the current ICHIA financing arrangement in two ways. First, some tax credits may never be taken by insurers and HMOs (see earlier discussion on this subject in Section III.). Second, the state earns interest on ICHIA assessment money between the time the assessment is imposed and the time the corresponding tax credit can be claimed in the following year (or longer for those firms that are unable to take credits in the first year available). As a result of the ICHIA assessment "float", the state's net liability for ICHIA losses is reduced by almost $800,000 in CY 2001 and almost $850,000 in CY 2002.[22] Thus, the net state liability for ICHIA is expected to increase from $27.44 million in CY 2001 to $29.2 million in CY 2002 under the current financing arrangement.

Hospital Admission Surcharge

One of the more important aspects of the hospital admission surcharge concept relates to the possible incidence of the surcharge: that is, who would ultimately pay the cost of the charge versus who is legally responsible for paying the charge. Would the hospitals simply have to incur the cost of the surcharge or would they be able to shift all or part of it to insurers and HMOs? Or, would insurers and HMOs be able to shift all or part of the surcharge to their customers via premium increases or service reductions? Or, would the admission surcharge to some extent be incident on all three of these groups? This will probably depend on various supply and demand factors that are beyond the parameters of this report. However, it is important to recognize the potential impacts of different incidence patterns.

First, one of the primary weaknesses of the current ICHIA financing arrangement is apparently that the member assessments only reach a small proportion of the population of health plans. This is, in part, because of the previously discussed federal ERISA provisions effectively prohibiting ICHIA assessments on self-insured plans.[23] If hospitals are able to shift the surcharge,

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[22] For purposes of estimating the interest earnings from the ICHIA assessment "float", we assume that the interest earned on the "float" is equal to 5.65% for six months. This interest rate is equal to the five-year average rate of return on state investments as of 1999.

[23]According the M-Plan testimony (September 20, 2000), the assessments are imposed on insurers and HMOs covering only 30% of the insured population. The organization *Communicating for Agriculture* reports that approximately 50% of people who have employer-sponsored insurance are covered by self insured plans that are, under federal ERISA provisions,

it would presumably be incident not only on insurers and HMOs currently paying ICHIA assessments but also on self-insured plans now excluded from the ICHIA financing arrangement. This may serve to increase the proportion of insurers and insurance consumers who subsidize the operating cost of ICHIA (depending on how readily insurers can shift the surcharge to insurance consumers). There is also a question of whether ERISA would preempt a state law providing for a hospital admission surcharge.

Second, if the cost of the hospital admission surcharge ends up being incurred by insurers and HMOs, this may impact the financial well-being of these entities. The Committee heard testimony as to the financial burden that the ICHIA assessments are already placing on insurers and HMOs. Insurers and HMOs who are already paying assessments would, under this proposal, have the additional cost of the admissions surcharge being shifted to them by hospitals. Finally, if hospitals are unable to shift the charge to insurers and insurance consumers, this may have a significant impact on the financial well-being of these entities.

Assessment Cap

Two aspects are worth considering relative to the proposed cap on insurer assessments. First, the proposed cap ($20 million) is an average of annual assessment receipts from recent years according to the Arnett Health Plans testimony and is well below the 1999 assessment level of $27.25 million (see Table 1). Thus, the cap would immediately create a funding gap that would have to be made up directly by state appropriations. Second, assuming the assessment cap was not adjusted for inflation and ICHIA program costs continue to increase, the member assessments would provide a decreasing percentage of funding for the program. Therefore, the funding gap that would be created initially by the $20 million cap and funded through state appropriations would continue to grow.

The net state liability for ICHIA is estimated to be $34.95 million in CY 2001 and about $37.6 million in CY 2002 under the proposal to cap insurer assessments at an aggregate level of $20 million per year, without changing the tax credits for such assessments (see Table 4).[24] Additionally, this proposal is estimated to increase the state's liability for covering ICHIA program losses (relative to the estimated liability under the current financing arrangement) by roughly $7.51 million in CY 2001 and $8.44 million in CY 2002.

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excluded from state-implemented assessment systems like that operated for ICHIA.

[24]We make the same assumptions in estimating program losses, tax credits, and return on ICHIA assessment "float" as were made previously.

Table 4. Fiscal Impact of Proposal for $20 Million Assessment Cap						
Calendar Year	Program Losses	Member Assessment Receipts	Direct State Liability	Tax Credits	Interest Earned from "Float"	Net State Liability
2001	$41,834,990	$20,000,000	$21,834,990	$13,500,000	$381,375	$34,953,615
2002	$44,516,218	$20,000,000	$24,516,218	$13,500,000	$381,375	$37,634,843

The state liability for covering ICHIA program losses under the $20 million assessment cap would increase because, as indicated above, the amount of program losses funded by assessments would immediately decline. This is the direct state liability listed in Table 4. The interest earned on the assessment "float" would decline due to the cap on assessments, and would reduce the state's ultimate liability by about $381,000 each year.

Refundable Tax Credit

One of the more important aspects of the fully refundable tax credit for ICHIA assessments would relate to its efficiency. If the tax credit is fully refundable then member assessments would be fully refunded. This would effectively return the financing of the program to what existed when ICHIA was created: a mixture of premium revenue and tax expenditures with member assessments only facilitating the financing (and tax expenditures equivalent to the amount of ICHIA losses). However, it also begs the question of whether it would simply be more efficient to appropriate tax dollars to fund ICHIA losses that would otherwise be defrayed by member assessments that ultimately would be fully refunded through the tax system. A rather circuitous route is taken ultimately to fund ICHIA losses with tax dollars via a tax expenditure. It may be important to consider what the administrative overhead is for insurers, HMOs, and ICHIA due to the payment and collection of the assessment and the maintenance and filing of the paperwork and records to obtain the tax credit. It may be important also to consider what the administrative overhead is for the Department of Revenue that results from the administration of the tax credit. These overhead costs (if they exist) represent a loss that would otherwise not arise if funds were simply appropriated for ICHIA.

The net state liability for ICHIA is estimated to be $40.65 million in CY 2001 and about $43.26 million in CY 2002 under the proposal to make the assessment tax credits fully refundable, without altering the current assessment arrangement (see Table 5).[25] What's more, this proposal is estimated to increase the state's liability for covering ICHIA program losses (relative to the estimated liability under the current financing arrangement) by roughly $13.2 million in CY 2001 and $14.1 million in CY 2002.

[25]We make the same assumptions in estimating program losses, tax credits, and return on ICHIA assessment "float" as were made previously.

Table 5. Fiscal Impact of Fully Refundable Assessment Tax Credit

Calendar Year	Program Losses	Tax Credits	Interest Earned from "Float"	Net State Liability
2001	$41,834,990	$41,834,990	$1,181,838	$40,653,151
2002	$44,516,218	$44,516,218	$1,257,583	$43,258,634

The state liability under the fully refundable assessment tax credit proposal increases substantially because the state would no longer benefit from assessments that insurers and HMOs are unable to offset under the current non-refundable tax credit arrangement. Consequently, the liability for ICHIA program losses would, under this proposal, fall entirely on the state treasury.

Full Funding Through State Appropriations

As to relying on appropriated dollars to fully cover ICHIA losses, reportedly there are both advantages and disadvantages.[26] By funding losses from general taxes, the problem of relying on a small proportion of the insured public for ICHIA funding would be eliminated. The cost of ICHIA not covered by those paying premiums would be distributed among the larger taxpaying public. On the other hand, if the state should experience an economic downturn, it could be difficult to maintain appropriation levels sufficient to cover ICHIA losses.

The net state liability for ICHIA is estimated to be $41.83 million in CY 2001 and about $44.5 million in CY 2002 under the proposal to eliminate the assessment arrangement and fully fund ICHIA program losses via state appropriations (see Table 5).[27] Additionally, we estimate that this proposal would increase the state's liability for covering ICHIA program losses (relative to the estimated liability under the current financing arrangement) by roughly $14.39 million in CY 2001 and $15.3 million in CY 2002.

Table 6. Fiscal Impact of Full Funding of ICHIA Program Losses

Calendar Year	Program Losses	Net State Liability
2001	$41,834,990	$41,834,990
2002	$44,516,218	$44,516,218

The state liability under the full-funding proposal increases substantially because the state would

[26]Communicating for Agriculture. (1999) Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis. Fergus Falls, MN: Communicating for Agriculture, Inc. p. 17.

[27]We make the same assumptions in estimating program losses as were made previously.

no longer benefit from assessments that insurers and HMOs are unable to offset with the tax credits, and the state would no longer obtain interest earnings from the ICHIA assessment "float".